Expanding Medicaid to the New Adult Group through Section 1115 Waivers

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) expanded Medicaid coverage to all adults under age 65 not otherwise eligible for Medicaid with incomes at or below 138 percent of the federal poverty level (FPL). After the June 2012 U.S. Supreme Court ruling in *NFIB v. Sebelius* effectively made Medicaid expansion under the ACA optional for states, a number of states have considered alternative approaches to extending coverage to previously ineligible adults.[1] As of July 2018, 33 states and the District of Columbia, have expanded Medicaid to previously ineligible adults.[2] Seven of these states—Arizona, Arkansas, Iowa, Indiana, Michigan, Montana, and New Hampshire—are currently providing Medicaid to the expansion population through Section 1115 research and demonstration waivers.[3] Though CMS also approved such a waiver for Kentucky, this approval was vacated and remanded to the U.S. Department of Health and Human Services (HHS) for further review by the U.S. District Court for the District of Columbia. Kentucky is not moving forward with implementation at this time but continues to operate a traditional Medicaid expansion.[4,5]

Section 1115 waivers allow states to test approaches that are not allowed under traditional Medicaid, such as the imposition of higher premiums for some enrollees and placing limitations on certain mandatory benefits. While each of the waiver programs is unique, there are some common themes. This issue brief summarizes the main design features of expansion waivers currently in operation, including benefits, premiums and cost sharing, premium assistance, and the delivery system. (For more details on the waivers, see Table 1 and state-specific fact sheets).

Populations Covered

In general, only the new adult group is covered through state Medicaid expansion waiver programs. However, Indiana's waiver extends premium and cost sharing requirements to other adults. All states but Michigan exclude people who are medically frail from mandatory enrollment in the waiver program. Additionally, New Hampshire exempts individuals in the new adult group who are eligible for the state Health Insurance Premium Payment (HIPP) program because they have access to cost-effective employer sponsored insurance.[6]

Eligibility and Enrollment

Five expansion waiver states—Arkansas, Indiana, Iowa, and New Hampshire—include policies related to eligibility and enrollment, including policies affecting the effective date of coverage, redetermination, and work and community engagement requirements.

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Effective date of coverage

Three states—Arkansas, Indiana, and Iowa—are exempt from the statutory requirement to provide three months of retroactive coverage.[7] In Arkansas, coverage begins 30 days prior to application. In Iowa, it begins on the first day of the month of application. In Indiana coverage begins on the first day of the month in which the first premium payment is made. In these two states, individuals with income above 100 percent FPL who do not make an initial payment within 60 days will not be enrolled. For those with incomes below 100 percent FPL who do not make an initial payment, coverage begins after the 60-day payment period expires. Individuals can also make an initial pre-payment to expedite coverage to begin the first day of the month in which the payment was made.

Redetermination

Indiana is permitted to disenroll members who do not submit information requested for their annual redetermination. Members can be disenrolled and prevented from reenrolling in coverage for three months.

Work and community engagement requirements

Arkansas, Indiana, and New Hampshire received approval to implement community engagement and employment requirements as a condition of eligibility for certain non-disabled adults.[8] These requirements are similar in many respects, but vary with regard to:

- which populations are required to participate in work or community engagement as a condition of eligibility;
- which individuals qualify for an exemption to the requirement;
- activities that qualify as work or community engagement;
- the number of hours beneficiaries are required to complete; and
- penalties for non-compliance.

Generally, unless enrollees meet an exemption, they are required to work or participate in an authorized activity for 80 hours per month (100 hours per month in New Hampshire). In all three states, beneficiaries who fail to comply with the requirements have their eligibility suspended until they comply, or are disenrolled for a specified time period. For more detail on individual state work and community engagement requirement policies and related guidance from CMS, see *Medicaid Work and Community Engagement Requirements.*

Benefits

States must use alternative benefit plans (ABPs), to provide coverage to the new adult group. The ABP must include the 10 ACA-required essential health benefits plus the mandatory Medicaid benefits of non-emergency transportation, federally qualified health center or rural health center services, family planning services and supplies, and early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21. Mental health parity rules apply as do all other Medicaid administrative and eligibility rules (42 CFR 440.345 and 42 CFR 440.347, Federal Register 2013).[9] Individuals who are

medically frail are exempt from mandatory enrollment in the ABP if it does not include all of the benefits provided under the Medicaid state plan.[10]

Several of the states receiving waivers have sought to exclude certain benefits, although not all of the proposed exclusions were approved. Most of the approved exclusions do not involve a substantial change in benefits. For example, in Indiana and Iowa, only non-emergency medical transportation (NEMT) has been excluded from the benefits offered.[11] In Arkansas and New Hampshire, which provide coverage through premium assistance (discussed below), Medicaid must provide benefits that are not otherwise available in the plans these states purchase on behalf of Medicaid beneficiaries. For example, these states provide EPSDT services to 19- and 20-year-olds as wrap-around services under their Medicaid fee-for-service delivery systems.

Premiums and Cost Sharing

Even without a waiver, states can require certain groups of Medicaid enrollees to pay enrollment fees, premiums, copayments, or other cost-sharing amounts, although federal guidelines specify who may be charged these fees, the services for which they may be charged, and the allowed amounts. Per-service charges are limited to nominal amounts for individuals with income at or below 100 percent FPL and are prohibited for certain services, such as emergency services. States also may not charge premiums for enrollees with income at or below 150 percent FPL. Total cost sharing (including premiums and per-service charges) is subject to an aggregate limit of five percent of family income (42 CFR 447.50-447.56).

The states with approved waivers sought changes to the premium and cost-sharing schedules so that all enrollees pay something, even nominally, toward the cost of coverage.[12] For example, Arkansas, Iowa, Michigan, and Montana charge monthly premiums. In Montana, premium payments are credited toward the enrollee's first 2 percent of copayments. Additionally, Arizona, Indiana, and Michigan use an approach similar to a health savings account in which enrollees make monthly or quarterly contributions toward payment for services. Additionally, most waiver programs require some level of point-of-service cost sharing. Arizona, Indiana, Iowa, and Michigan also provide credits or discounts on premiums or health savings account contributions based on the completion of certain healthy behavior requirements, such as getting a risk assessment or annual wellness exam.[13]

In all of these waiver programs, enrollees remain protected by the Medicaid rule limiting aggregate out-of-pocket spending on premiums and cost sharing to 5 percent of income. Additionally, while enrollees with incomes below 100 percent FPL may be charged premiums, they are not at risk of losing their Medicaid coverage due to nonpayment. However, Arizona, Indiana, Iowa, and Montana are permitted to disenroll individuals with incomes over 100 percent FPL for nonpayment of premiums. In Arizona and Iowa, individuals who are disenrolled for nonpayment of premiums can re-enroll at any time regardless of any outstanding unpaid premiums. In Indiana they are denied reenrollment for six months, and in Montana, they are able to re-enroll once they pay overdue premiums or their premium debt is assessed against their state taxes.

Premium Assistance

Premium assistance is the state purchase of private market coverage on behalf of Medicaid enrollees, such as employer-sponsored insurance or qualified health plans on the exchange. Three of the waiver states use some type of premium assistance in their expansions. In Arkansas and New Hampshire, adults are enrolled in exchange plans. Beginning in April 2018, individuals in Michigan will have the choice of enrolling in Medicaid or an exchange plan. In New Hampshire, new adult group enrollees also may be enrolled in cost-effective employer-sponsored coverage in premium assistance arrangements.

Delivery System

In general, states either offer Medicaid benefits on a fee-for-service (FFS) basis, through Medicaid managed care plans, or through some combination of the two. Under the FFS model, the state pays providers directly for each covered service provided to a Medicaid enrollee. Under managed care, the state pays a monthly premium to a managed care plan for each person enrolled in the plan. Arizona, Indiana, Iowa, and Michigan waivers provide services to new adult enrollees through managed care plans. In their waiver programs, Arkansas, Michigan, and New Hampshire use some form of premium assistance to provide benefits to covered populations through exchange or employer-sponsored plans with the Medicaid fee-for-service program providing wrap-around benefits.[14] Montana has a contract with a third-party administrator for the fee-for-service coverage of health care services for most adults in the new group with incomes between 50 and 138 percent FPL.

Conclusion

Seven states are currently operating Section 1115 waivers to implement Medicaid expansion. While the terms of each state's waiver vary, the waivers generally do not involve a substantial change in benefits compared to those offered in Medicaid. Arkansas, and Indiana are the only states currently authorized to require participation in work or community engagement activities as a condition of eligibility. Although all states are charging some level of cost sharing, it is still subject to the five percent of income cap. Enrollment of individuals with incomes below 100 percent FPL cannot be contingent on payment of premiums. Three states are using some sort of premium assistance.

Because Section 1115 waivers are experiments, pilots, or demonstration programs, they require evaluation. As such, each of these varied approaches to coverage for the new adult group may provide data on the effect of changes in benefits and cost sharing on enrollment, access to care, and service use, which can inform future policy. However, data will not be available on the full extent of the waivers for several years.

TABLE 1. Summary of Key Provisions in Approved Section 1115 Medicaid Expansion Waivers

State	Eligibility and enrollment	Benefits	Premiums and cost sharing	Premium assistance	Delivery system
Arizona	none	no waived benefits	individual accounts with monthly contributions for enrollees >100% FPL; premiums waived for healthy behaviors; disenrollment for non-payment; copayments ranging from $4 to $10 required for select services for enrollees >100% FPL	none	Medicaid managed care
Arkansas	retroactive coverage waived, work and community engagement requirement for new adult group age 19 to 49; disenrollment and lockout for non-compliance with work requirement	no waived benefits	premiums and copayments for enrollees > 100 percent FPL	exchange plans	commercial exchange coverage with FFS wrap
Indiana	retroactive coverage waived; work and community engagement requirement for non-disabled adults age 19 to 64; eligibility suspended for non-compliance	NEMT	individual accounts with monthly contributions for all enrollees; disenrollment and lock-out for those > 100% FPL who don't contribute; copayments for those ≤ 100% FPL	none	Medicaid managed care

TABLE 1. (continued)

State	Eligibility and enrollment	Benefits	Premiums and cost sharing	Premium assistance	Delivery system
	with work requirement; disenrollment and lockout for failure to submit information necessary for redetermination.		who don't contribute; credits for healthy behaviors.		
Iowa	retroactive coverage waived	NEMT	premiums for enrollees >50% FPL; premiums waived in the first year and for healthy behaviors thereafter; disenrollment for non-payment of premiums for enrollees >100% FPL; copayment for non-emergency use of the ED	none	Medicaid managed care
Kentucky (as approved by CMS)	retroactive coverage waived; work and community engagement requirement for non-disabled adults age 19 to 64; eligibility suspended for non-compliance with work requirement and disenrollment and lockout for failure to submit information necessary for redetermination.	NEMT	premiums between $1.00 and 4 percent of income; disenrollment and lockout for those > 100% FPL for nonpayment; copayments for <100% FPL	employer-sponsored insurance	Medicaid managed care and employer sponsored insurance with FFS wrap

TABLE 1. (continued)

State	Eligibility and enrollment	Benefits	Premiums and cost sharing	Premium assistance	Delivery system
Michigan	none	no waived benefits	all enrollees subject to copayments; premiums for enrollees >100% FPL; payments go toward a health account; credits for healthy behaviors	exchange plans (beginning in April 2018)	Medicaid managed care and exchange coverage with FFS wrap
Montana	none	no waived benefits	monthly premiums for enrollees > 50% FPL that are credited toward copayments; disenrollment for those > 100% for non-payment of premiums	none	FFS
New Hampshire	retroactive coverage waived, work and community engagement requirement for new adult; eligibility suspended for non-compliance with work requirement group	no waived benefits	copayments for enrollees >100% FPL	exchange plans; employer-sponsored insurance premium assistance offered through a separate state program	exchange or employer-sponsored coverage with FFS wrap

Notes: ED is emergency department. FFS is fee for service. NEMT is non-emergency medical transportation. Approval of New Hampshire's waiver of retroactive coverage is pending state submission of data and analysis to CMS. For more detail on specific state policies, see individual state fact sheets. For more detail on specific exemptions and ways to satisfy work requirements, see *Medicaid work and community engagement requirements*.

Source: MACPAC 2018 analysis of Section 1115 Medicaid expansion waivers.

Endnotes

[1] *NFIB v. Sebelius*, 567 U.S. 519 (2012), 132 S.Ct 2566.

[2] Maine adopted the Medicaid expansion by voter referendum in November 2017, but has not yet begun enrolling its expansion population. Virginia adopted a state budget that includes Medicaid expansion in May 2018, but has not yet begun enrolling its expansion population.

[3] A Section 1115 waiver gives broad authority to the Secretary of HHS to authorize an experimental, pilot, or demonstration project that is likely to assist in promoting the objectives of a state's Medicaid program. Section 1115 waivers allow the Secretary to waive certain provisions of the Medicaid statutes related to state program design, and are generally broad in scope, operate statewide, and affect a large portion of the Medicaid population within a state.

Pennsylvania received approval for a five-year waiver called Healthy Pennsylvania, which began enrolling individuals on January 1, 2015. Healthy Pennsylvania provided coverage to enrollees through Medicaid managed care. Outside of the demonstration, the state planned to encourage employment through job training and work-related activities. However, a new governor was elected in November 2014 who took action to end the waiver and transition the state to a traditional Medicaid expansion, halting the implementation of some waiver activities that were to begin in the second year of the waiver and rolling back waiver activities that had already begun. The transition was fully implemented on September 1, 2015 (Office of Governor Tom Wolf 2015).

[4] Because Kentucky's waiver was sent back to CMS for reconsideration, this brief does not discuss the features of Kentucky's waiver as approved provisions. For details on the waiver provisions approved by CMS, see the MACPAC fact sheet on the Kentucky Medicaid Expansion Waiver.

[5] *Stewart et al. v. Azar et al., 1:18-cv-00152 (U.S. District Court for the District of Columbia 2018.*

[6] Cost effectiveness for premium assistance means that the total cost of purchasing premium assistance coverage including administrative expenditures, coverage of excess cost sharing charges, and the costs of providing wrap-around benefits, must be comparable to the cost of providing traditional coverage under the state plan (42 CFR 435.1015(a)(4)).

[7] Retroactive coverage is still provided to other populations, including pregnant women in Indiana. New Hampshire has a provisional waiver of retroactive coverage conditioned upon data demonstrating that the state system ensures that enrollees do not have gaps in coverage of needed services.

[8] Other expansion states (Arizona, Kentucky, and New Hampshire) as well as additional non-expansion states (Kansas, Maine, Mississippi, North Carolina, Ohio, Utah, and Wisconsin) have formally applied to CMS for permission to implement similar requirements. Though CMS approved Kentucky's request, the approval was vacated and remanded back to the agency for further review. Maine opted to expand Medicaid by voter referendum but has not yet implemented the expansion. North Carolina would only implement a work requirement if it also implements Medicaid expansion through the state legislative process. According to press reports Alabama, Connecticut, Idaho, Michigan, Louisiana, Oklahoma, South Carolina, South Dakota and Virginia have expressed interest in applying for such waivers but only states with formal waiver applications are included in this fact sheet.

[9] An alternative benefit plan (ABP) offers an option to states to provide alternative benefits specifically tailored to meet the needs of certain Medicaid population groups or provide services through specific delivery systems, instead of following the traditional Medicaid benefit plan. All states that expand Medicaid are required to submit an ABP to denote any differences in benefit coverage between the base population and expansion population, or to note that they are offering the same benefit coverage to all enrollees in the base and expansion populations.

[10] Most other exempt individuals may be eligible for coverage under another eligibility pathway (e.g., disability-related coverage). Because medically frail individuals do not become eligible for Medicaid through a separate pathway, they are most likely to be enrolled in the new adult group. The federal definition of medically frail includes individuals with disabling mental health disorders, chronic substance use, serious and complex medical conditions, a physical or mental disability that significantly impairs their ability to perform one or more activities of daily living, or other special medical needs (42 CFR 440.315(f)).

[11] Initially in Indiana and Iowa's demonstrations, NEMT was waived for the first year. Both states have received extensions of this authority and currently are not providing NEMT to the new adult group.

[12] Under Section 1115 authority, the Secretary can waive premium requirements; however Section 1916(f) sets limits on changes that can be made to cost-sharing provisions through a waiver.

[13] Both Arkansas's and Montana's waiver also mention the use of healthy behavior incentives, but no further details are provided.

[14] Iowa previously provided coverage through exchange plan premium assistance to enrollees with incomes over 100 percent FPL, but discontinued the program in 2016 due to plans dropping out of participation.

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